

## HEALTH CHALLENGES AND NUTRITIONAL LIFESTYLES OF THE ELDERLY IN RURAL AND URBAN HOUSEHOLDS OF ATIBA LOCAL GOVERNMENT OF OYO STATE

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### ABSTRACT

*Aging is complex, and by age 65, most elderly people suffer or experience one health challenge or the other. Nigeria is believed to have the largest concentration of elderly people in Africa, and was expected to have hit 30million by 2016. Even though, genetics play key role in health and longevity, diet, environmental hazard, medical support and access to health information are found relevant. Nutritional and health status assessment of selected elderly respondents were carried out to determine their well-being in view of present economic challenges. Stratified random sampling technique was used to select sixty elderly male and female from the rural and urban settlements of Atiba local government area of Oyo state. Structured questionnaire on demographic, dietary lifestyle and health history was used to elicit information from the elderly respondents while frequency counts and simple percentages were used to analyse the responses. It was noted that little disparity existed among the elderly in terms of lifestyle, dietary pattern and health issues despite their residencies. Majority of the urban elderly were retiree from government services and artisans while their rural counterparts were basically farmers and traders during their active years. It was recommended that children and relatives of elderly people should be more supportive and that the government should subsidise health care services of the elderly and grant pensionable supports to government retirees.*

**Keywords:** *elderly, dietary lifestyle, ageing, rural, urban, socioeconomic status*

### INTRODUCTION

The number of elderly people is rapidly increasing while their socioeconomic status or those of their family members are not adequate to offer them the necessary support to enjoy their old age. Davis and Bartlett (2008) noted that a considerable number of them exist in most rural and urban communities. For an ageing population, health is an increasingly important issue because longer and more active participation in society not only depends on a longer lifespan but also on higher levels of well-being with lower levels of ill-health or susceptibility to the major illnesses associated with ageing and chronic diseases in later life. Also, good eating habits and healthy lifestyle support longevity and a better health status.

Diet is a major factor influencing the health to prevent chronic non-communicable diseases. Most health problems are reflected by the incidence of diseases like obesity, diabetes, cardiovascular disease, stroke, hypertension, and some types of cancer associated with premature

death, excessive morbidity and serious psychosocial problems. Inappropriate dietary intake and chronic diseases place a substantial number of older adults at high risks of malnutrition and health challenges. Such risks often result in dysfunction and disability, reduced quality of life and in some instances, premature or increased morbidity and mortality (Favaro-Moreira, 2016). Rexroth (2013) drew a relationship between demographic, health factors and cognition in older adults while Kave (2018) adjudged the well-being of certain elderly subjects to their socio-demographic factors.

Anyakoha (2015) noted that the aged or the elderly (age 60 and above) may have problem with digestion and absorption of food due to decrease in digestive enzyme. Some may also have dental problem resulting from inadequate intake of nutritious food in addition to certain health challenges. Those that are restricted indoor may also lack vitamin D resulting in weak bones. Smith and Ojofeitimi (1995) analysed the important food nutrients appropriate for an adequate, essential and sufficient diet for the wellbeing of the elderly. Poor nutrition result from poverty, isolation, mal-distribution of food, poor eating habit, dental problem, health challenges and other peculiar age-related situations according to Eastwood and Passmore (1992).

Kye, Arenas, Ternel and Rubalcaus (2014) reported that higher educational attainment ensure better demographic behaviour that beneficially affect health and life of the elderly and their offspring. Education of children is also positively associated with the health and survival chances of the elderly because better educated children provide their parents with more support. Care and support of the elderly in African setting largely rest on the immediate and extended family members rather than social services burden. It is expected that their health and wellbeing be dependent on the integral existence of the informal services, social support network and kin (family) support or assistance. Connidis (2010) underscore the role of family ties in ageing, especially the presence of children, grandchildren and other close family members. Loneliness, financial instability and emotional strain had been cited as challenges for the elderly (Selvaratnam & Poo, 2007). Most aged may not always enjoy the presence of their partner in later life drawing a perspective in intergenerational relations as support of the adult children or the presence of grandchildren to meet up with the social activity in later life.

Nutrition related disorders associated with ageing include osteoporosis which reflects only in advanced stages as pain and fracture resulting in morbidity, muscle waste and loss of lean body mass. Nnanyelugo, Kubianga and Akpanyung (1978) reported cases of gradual reduction of energy intake with increasing age due to diminishing ability to swallow. An increasing number of people are experiencing health problems due to their overall lifestyle which has been gradually changing with time whereas nutrition can strongly contribute to the prevention of accumulating chronic diseases. Obesity, diabetes, cardiovascular disease, stroke, hypertension, and some types of cancer arising from inappropriate diet, poor quality of nutrition, and lack of physical activity are detrimental to health.

Poor eating habits and low exercise levels correlate to increased physical ageing characteristics for the elderly (Selvaratnam, 2008). Prevalence of malnutrition increases with age for the elderly especially the women beyond the age of seventy (70). Nutritional status relates to functional

ability, hand grip strength and psychomotor coordination. The consumption lifecycle theory argues that after retirement from a paid job a person will either maintain their lifestyle or face a decline in the consumption pattern due to loss of income. The elderly who are not prepared and who used to be robust in their working days will be the hardest hit. This burden is escalated when poor diet and lack of exercise causes a decline in the general health of the individual leading to a rise in demand for health facilities and medicine.

Eastwood and Passmore, (1992) actually recommended nutritional assessment as anthropometric, clinical and biochemical tests in addition to dietary surveys for health and well-being determination of the elderly. The food intake, lifestyle pattern and health records of these elderly subjects would provide insight into their health and nutritional status and help to proffer solutions to pertinent issues for alleviating prevailing health challenges. Observations revealed prevalent health and nutritional challenges among the elderly in Atiba local government area of Oyo State. Therefore, it is pertinent to obtain information from selected elderly male and female subjects in rural and urban communities of the study area.

### **OBJECTIVES OF THE STUDY**

This paper intended to:-

1. Study socio-demographic characteristics of urban and rural elderly in the study area
2. Discover nutritional and health problems prevalent among elderly in the study area
3. Examine the differences between rural and urban elderly based on dietary intake and lifestyles.

### **RESEARCH QUESTIONS**

1. What are the socio-demographic characteristics of the elderly in the study area?
2. How are the dietary and lifestyle of the elderly subjects in the study area?
3. Would there be differences between the nutritional and health status of rural and urban elderly in the study area?

### **METHODOLOGY**

Stratified random sampling technique was used to select sixty elderly male and female from the rural and urban settlements of Atiba local government area of Oyo state. An elderly man is selected from every fifth household in a pre-selected area while an elderly woman is selected from opposite or adjoining household as the case may be. However, where such a household could not produce the subject, it is skipped for the next selection. This was carried out for both the rural and the urban households in the local government area used for the study. The rural settings include Adaralode, Agba-akin, Asamu, Ida-ogun and Odo-owo, while the urban settings include Elere, Iyalamu, Koso, Sabo and Sakutu. Structured questionnaire on demographic, dietary lifestyle and health history was used to elicit information from the elderly respondents while frequency counts and simple percentages were used to analyse the responses in tabulated presentation.

**RESULTS****Table I: Demographic characteristics of the elderly in the study areas**

Age range (years)	Rural male	Rural Female	%	Urban Male	Urban Female	%
<b>60-64</b>	3	4	23.33	6	3	30.00
<b>65-74</b>	4	6	33.33	5	6	36.67
<b>75-84</b>	6	2	26.67	3	4	23.33
<b>85-94</b>	2	3	16.67	1	2	10.00
<b>Above 94</b>	-	-	-	-	-	—
<b>Total</b>	<b>15</b>	<b>15</b>	<b>100.00</b>	<b>15</b>	<b>15</b>	<b>100.00</b>

The respondents were between the ages of sixty and ninety-four, most of them were in the age range of 65-74, with 33.33% in the rural and 36.67% in the urban. Only few were in the age range of 85-94 with 16.67% in the rural and 10% in the urban as depicted on Table I.

**Table II: Educational background of rural and urban elderly in the study area**

Educational level	Rural Male	Rural Female	%	Urban Male	Urban Female	%
None formal	5	8	43.33	3	5	26.67
Primary	7	7	46.67	3	6	30.00
Post-primary/secondary	3	--	10.00	6	3	30.00
Post-secondary/tertiary	-	-	-	3	1	13.33
Others	-	-	-	-	-	—
<b>Total</b>	<b>15</b>	<b>15</b>	<b>100.00</b>	<b>15</b>	<b>15</b>	<b>100.00</b>

Only 13.33% of the urban elderly, but none of the rural elderly had beyond secondary education. A considerable number (43.33%) of the rural elderly some (26.67%) of their urban counterparts had no formal education. From table 2, however, 46.67% of the rural elderly and 30% of the urban elderly still had basic education. Also, 10% of the rural and 30% of the urban elderly had post primary education.

**Table III: Occupational engagement of the elderly during their active years**

Occupation	Rural Male	Rural Female	%	Urban Male	Urban Female	%
<b>Farming</b>	8	3	36.67	-	-	-
<b>Hunting</b>	2	-	6.66	-	-	-
<b>Trading</b>	3	8	36.67	3	9	40.00
<b>Artisan</b>	2	4	20.00	6	4	33.33
<b>Civil service</b>	-	-	-	6	2	26.67
<b>Total</b>	<b>15</b>	<b>15</b>	<b>100.00</b>	<b>15</b>	<b>15</b>	<b>100.00</b>

The elderly respondents were not redundant in their active years as noted on table III. Farming and trading were most common (36.67%) among the rural elderly while few (6.67%) were hunters. Only the urban elderly (26.67%) were engaged as civil servants while majority (40%) of them were traders and a considerable number (33.33%) were also artisans but none were farmers.

**Table IV: Number of children of rural and urban elderly in the study area**

Children	Rural Male	Rural Female	%	Urban Male	Urban Female	%
<b>Less than five</b>	5	8	43.33	9	11	66.67
<b>More than five</b>	10	7	56.67	6	4	33.33
<b>Total</b>	<b>15</b>	<b>15</b>	<b>100.00</b>	<b>15</b>	<b>15</b>	<b>100.00</b>

Only 45% of them had more than five children while 55% had less than five children, basically among the urban elderly as stated on table 4.

**Table V: Present lifestyle of rural and urban elderly in the study area**

Lifestyle	Rural Male	Rural Female	%	Urban Male	Urban Female	%
<b>Active</b>	4	8	40.00	10	10	66.67
<b>Sedentary</b>	11	7	60.00	5	5	33.33
<b>Total</b>	<b>15</b>	<b>15</b>	<b>100.00</b>	<b>15</b>	<b>15</b>	<b>100.00</b>

Table V reveals that most (66.67%) of the urban elderly were still actively engaged in one socio-economic activity or the other, while more (60%) of the rural elderly were more sedentary after years of active activity.

**Table VI: Living and accommodation of rural and urban elderly in the study area**

Living condition	Rural Male	Rural Female	%	Urban Male	Urban Female	%
<b>Living on their own</b>	4	2	20.00	4	5	30.00
<b>Living with their children</b>	6	5	36.67	5	2	23.33
<b>Living with grandchildren</b>	4	6	33.33	4	5	30.00
<b>Living with house-help</b>	1	2	10.00	2	3	16.67
<b>Total</b>	<b>15</b>	<b>15</b>	<b>100.00</b>	<b>15</b>	<b>15</b>	<b>100.00</b>

Only 10% of the rural elderly and 16.67% of the urban elderly needed the assistance and care of house helps, while 20% lived alone in the rural, 30% lived in their urban housing alone. However, 36.67% in the rural and 23.33% in the urban still enjoyed the company and support of their children. About 33.33% rural elderly and 30% urban elderly had their grand-children staying with them for social and emotional supports.

**Table VII: Food consumption pattern of the rural and urban elderly**

<b>Dietary intake</b>	<b>Rural Male</b>	<b>Rural Female</b>	<b>%</b>	<b>Urban Male</b>	<b>Urban Female</b>	<b>%</b>
<b>**multiple responses</b>						
Beans & bean products	10	13	76.67	13	12	83.33
Rice in various forms	12	15	90.00	12	12	80.00
Yam & pounded yam	15	14	96.67	12	13	83.33
Bread and other cereals	05	11	53.33	12	12	80.00
Cassava meal & products	02	10	40.00	12	12	80.00
Beef and red meats	11	12	76.67	11	12	76.67
Fish and poultry	15	12	90.00	12	11	76.67
Local cheese products	15	14	96.67	11	11	73.33
Milk, eggs and dairy	10	10	66.67	10	10	66.67
Green & leafy vegetables	15	15	100.00	11	12	76.67
Fruits (citrus, mango etc.)	10	12	73.33	14	14	93.33
Indigenous snacks	12	13	83.33	13	13	86.67
Beverages	10	10	66.67	13	12	83.33
Canned foods	06	07	43.33	10	10	66.67
Local herbs/concoction	13	14	90.00	10	15	83.33
Alcohol & tobacco	04	00	13.33	03	00	10.00

From Table VII, it is revealed that appropriate dietary intake was observed by the rural and urban elderly from the various groups and classes of available foods. Except for canned foods, cassava products and also alcohol and tobacco; with consumption below average, all other categories of food were well consumed by the rural elderly. However, all categories of food were generously taken by the urban elderly except for their glaring detest of alcohol and tobacco with only 10% consumption.

**Table VIII: Commonly experienced health challenges by rural and urban elderly in the study area**

<b>Health challenges</b>	<b>Rural Male</b>	<b>Rural Female</b>	<b>%</b>	<b>Urban Male</b>	<b>Urban Female</b>	<b>%</b>
<b>**multiple responses</b>						
Eye sight problem	10	10	66.67	13	12	83.33
Hearing impairment	07	06	43.33	05	04	30.00
Arthritis / mobility	10	12	73.33	12	13	83.33
High blood pressure	02	05	23.33	08	07	50.00
Diabetes	-	-	-	02	02	13.33
Anaemia	01	02	10.00	01	02	10.00
Serious teeth loss	03	03	20.00	03	02	16.67
No challenging illness	05	04	30.00	02	01	10.00

Table VIII recorded the common health challenges among the rural elderly as arthritis (73.33%) which affected mobility with both arthritis and eye problem (83.33%) for the urban elderly. Diabetes was rare among the rural elderly but affected 13.33% of the urban elderly. High blood pressure was evident among 50% of the urban elderly and 23.33% of their rural counterparts. Even then, 30% of rural elderly and 10% of urban elderly still enjoyed good health and experienced no challenging ailment.

### DISCUSSION ON FINDINGS

A fair academic exposure is observed among the respondents and according to Kye, Arenas, Ternel and Rubalcaus (2014), this is expected to ensure relevant nutritional and lifestyle information. That a good number of them lived beyond the retirement age is partly credited to conduciveness of environment, good socio-demographic qualities, befitting dietary and active social lifestyle as related by Rexroth (2013). The fact that most of the elderly enjoyed close family support and rapport rather than being left on their own or left to the care of paid services is an addition to their well-being as asserted by Connidis (2010).

There is evidence of good dietary habit and intake among both rural and urban elderly in the study area. Anyakoha (2015) suggested that the elderly remain as active as possible in order to stimulate digestion and strengthen their bones and muscles. The elderly under this study were active even in old age. All categories of food were generously taken by most of the elderly and there was even glaring detest of alcohol and tobacco.

### CONCLUSIONS AND RECOMMENDATIONS

When social and dietary lifestyle changes as ageing sets in, and there is inadequate care, poor environmental conditions, prevailing health challenges or other existing or prevailing health challenges, there is bound to be early morbidity or mortality. Identified malnutrition risks of the elderly include vitamins, mineral deficiencies, obesity or under-nutrition, hypertension resulting from poverty and inadequate care.

It was recommended that children and relatives of elderly people should be more supportive and that the government should subsidise health care services of the elderly and grant pensionable supports to government retirees. Moreso, as the socio-political situation in the country presently is not guaranteeing longevity and satisfactory ageing for the general populace.

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